26-18-1. Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

Enacted by Chapter 126, 1981 General Session

26-18-2. Definitions.

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

(2) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

(3) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.

(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.

(6) (a) "Passenger vehicle" means a self-propelled, two-axle vehicle intended primarily for operation on highways and used by an applicant or recipient to meet basic transportation needs and has a fair market value below 40% of the applicable amount of the federal luxury passenger automobile tax established in 26 U.S.C. Sec. 4001 and adjusted annually for inflation.

(b) "Passenger vehicle" does not include:

(i) a commercial vehicle, as defined in Section 41-1a-102;

(ii) an off-highway vehicle, as defined in Section 41-1a-102; or

(iii) a motor home, as defined in Section 13-14-102.

(7) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

Amended by Chapter 1, 2000 General Session

26-18-2.1. Division -- Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

Enacted by Chapter 21, 1988 General Session

26-18-2.2. Director -- Appointment -- Responsibilities.

The director of the division shall be appointed by the governor, after consultation with the executive director, with the advice and consent of the Senate. The director of

the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) prepare and administer the division's budget; and

(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

Amended by Chapter 267, 2011 General Session

26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:

(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;

(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and

(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) consistent with Sections 26-18-2.4 and 58-17b-606, a Medicaid drug program;

(g) coordination of benefits; and

(h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

(4) The department shall ensure Medicaid program integrity by conducting internal audits of the Medicaid program for efficiencies, best practices, fraud, waste, abuse, and cost recovery.

(5) The department shall, by December 31 of each year, report to the Social Services Appropriations Subcommittee regarding:

(a) measures taken under this section to increase:

(i) efficiencies within the program; and
(ii) cost avoidance and cost recovery efforts in the program; and
(b) results of program integrity efforts under Subsection (4).

Amended by Chapter 242, 2012 General Session

26-18-2.4. Medicaid drug program -- Preferred drug list.

(1) A Medicaid drug program developed by the department under Subsection 26-18-2.3 (2)(f):

(a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and cost-related factors which include medical necessity as determined by a provider in accordance with administrative rules established by the Drug Utilization Review Board;

(b) may include therapeutic categories of drugs that may be exempted from the drug program;

(c) may include placing some drugs, except the drugs described in Subsection (2), on a preferred drug list to the extent determined appropriate by the department;

(d) notwithstanding the requirements of Part 2, Drug Utilization Review Board, shall immediately implement the prior authorization requirements for a nonpreferred drug that is in the same therapeutic class as a drug that is:

(i) on the preferred drug list on the date that this act takes effect; or

(ii) added to the preferred drug list after this act takes effect; and

(e) except as prohibited by Subsections 58-17b-606(4) and (5), shall establish the prior authorization requirements established under Subsections (1)(c) and (d) which shall permit a health care provider or the health care provider's agent to obtain a prior authorization override of the preferred drug list through the department's pharmacy prior authorization review process, and which shall:

(i) provide either telephone or fax approval or denial of the request within 24 hours of the receipt of a request that is submitted during normal business hours of Monday through Friday from 8 a.m. to 5 p.m.;

(ii) provide for the dispensing of a limited supply of a requested drug as determined appropriate by the department in an emergency situation, if the request for an override is received outside of the department's normal business hours; and

(iii) require the health care provider to provide the department with documentation of the medical need for the preferred drug list override in accordance with criteria established by the department in consultation with the Pharmacy and Therapeutics Committee.

(2) (a) For purposes of this Subsection (2):

(i) "Immunosuppressive drug":

(A) means a drug that is used in immunosuppressive therapy to inhibit or prevent activity of the immune system to aid the body in preventing the rejection of transplanted organs and tissue; and

(B) does not include drugs used for the treatment of autoimmune disease or diseases that are most likely of autoimmune origin.

(ii) "Psychotropic drug" means the following classes of drugs: atypical anti-psychotic, anti-depressants, anti-convulsant/mood stabilizer, anti-anxiety, attention deficit hyperactivity disorder stimulants, or sedative/hypnotics.

(iii) "Stabilized" means a health care provider has documented in the patient's medical chart that a patient has achieved a stable or steadfast medical state within the past 90 days using a particular psychotropic drug.

(b) A preferred drug list developed under the provisions of this section may not include:

(i) except as provided in Subsection (2)(e), a psychotropic or anti-psychotic drug; or

(ii) an immunosuppressive drug.

(c) The state Medicaid program shall reimburse for a prescription for an immunosuppressive drug as written by the health care provider for a patient who has undergone an organ transplant. For purposes of Subsection 58-17b-606(4), and with respect to patients who have undergone an organ transplant, the prescription for a particular immunosuppressive drug as written by a health care provider meets the criteria of demonstrating to the Department of Health a medical necessity for dispensing the prescribed immunosuppressive drug.

(d) Notwithstanding the requirements of Part 2, Drug Utilization Review Board, the state Medicaid drug program may not require the use of step therapy for immunosuppressive drugs without the written or oral consent of the health care provider and the patient.

(e) The department may include a sedative hypnotic on a preferred drug list in accordance with Subsection (2)(f).

(f) The department shall grant a prior authorization for a sedative hypnotic that is not on the preferred drug list under Subsection (2)(e), if the health care provider has documentation related to one of the following conditions for the Medicaid client:

(i) a trial and failure of at least one preferred agent in the drug class, including the name of the preferred drug that was tried, the length of therapy, and the reason for the discontinuation;

(ii) detailed evidence of a potential drug interaction between current medication and the preferred drug;

(iii) detailed evidence of a condition or contraindication that prevents the use of the preferred drug;

(iv) objective clinical evidence that a patient is at high risk of adverse events due to a therapeutic interchange with a preferred drug;

(v) the patient is a new or previous Medicaid client with an existing diagnosis previously stabilized with a nonpreferred drug; or

(vi) other valid reasons as determined by the department.

(g) A prior authorization granted under Subsection (2)(f) is valid for one year from the date the department grants the prior authorization and shall be renewed in accordance with Subsection (2)(f).

(3) The department shall report to the Health and Human Services Interim Committee and to the Social Services Appropriations Subcommittee prior to November 1, 2013, regarding the savings to the Medicaid program resulting from the use of the preferred drug list permitted by Subsection (1).

Amended by Chapter 242, 2012 General Session
Amended by Chapter 343, 2012 General Session

26-18-2.5. Simplified enrollment and renewal process for Medicaid and other state medical programs -- Financial institutions.

(1) The department may:

(a) apply for grants and accept donations to:

(i) make technology system improvements necessary to implement a simplified enrollment and renewal process for the Medicaid program, Utah Premium Partnership, and Primary Care Network Demonstration Project programs; and

(ii) conduct an actuarial analysis of the implementation of a basic health care plan in the state in 2014 to provide coverage options to individuals from 133% to 200% of the federal poverty level; and

(b) if funding is available:

(i) implement the simplified enrollment and renewal process in accordance with this section; and

(ii) conduct the actuarial analysis described in Subsection (1)(a)(ii).

(2) The simplified enrollment and renewal process established in this section shall, in accordance with Section 59-1-403, provide an eligibility worker a process in which the eligibility worker:

(a) verifies the applicant's or enrollee's identity;

(b) gets consent to obtain the applicant's adjusted gross income from the State Tax Commission from:

(i) the applicant or enrollee, if the applicant or enrollee filed a single tax return; or

(ii) both parties to a joint return, if the applicant filed a joint tax return; and

(c) obtains from the State Tax Commission, the adjusted gross income of the applicant or enrollee.

(3) (a) The department may enter into an agreement with a financial institution doing business in the state to develop and operate a data match system to identify an applicant's or enrollee's assets that:

(i) uses automated data exchanges to the maximum extent feasible; and

(ii) requires a financial institution each month to provide the name, record address, Social Security number, other taxpayer identification number, or other identifying information for each applicant or enrollee who maintains an account at the financial institution.

(b) The department may pay a reasonable fee to a financial institution for compliance with this Subsection (3), as provided in Section 7-1-1006.

(c) A financial institution may not be liable under any federal or state law to any person for any disclosure of information or action taken in good faith under this Subsection (3).

(d) The department may disclose a financial record obtained from a financial institution under this section only for the purpose of, and to the extent necessary in, verifying eligibility as provided in this section and Section 26-40-105.

Amended by Chapter 279, 2012 General Session

26-18-2.6. Dental benefits.

(1) (a) Except as provided in Subsection (8), the division shall establish a

competitive bid process to bid out Medicaid dental benefits under this chapter.

(b) The division may bid out the Medicaid dental benefits separately from other program benefits.

(2) The division shall use the following criteria to evaluate dental bids:

(a) ability to manage dental expenses;

(b) proven ability to handle dental insurance;

(c) efficiency of claim paying procedures;

(d) provider contracting, discounts, and adequacy of network; and

(e) other criteria established by the department.

(3) The division shall request bids for the program's benefits:

(a) in 2011; and

(b) at least once every five years thereafter.

(4) The division's contract with dental plans for the program's benefits shall include risk sharing provisions in which the dental plan must accept 100% of the risk for any difference between the division's premium payments per client and actual dental expenditures.

(5) The division may not award contracts to:

(a) more than three responsive bidders under this section; or

(b) an insurer that does not have a current license in the state.

(6) (a) The division may cancel the request for proposals if:

(i) there are no responsive bidders; or

(ii) the division determines that accepting the bids would increase the program's costs.

(b) If the division cancels the request for proposals under Subsection (6)(a), the division shall report to the Health and Human Services Interim Committee regarding the reasons for the decision.

(7) Title 63G, Chapter 6a, Utah Procurement Code, shall apply to this section.

(8) (a) The division may:

(i) establish a dental health care delivery system and payment reform pilot program for Medicaid dental benefits to increase access to cost effective and quality dental health care by increasing the number of dentists available for Medicaid dental services; and

(ii) target specific Medicaid populations or geographic areas in the state.

(b) The pilot program shall establish compensation models for dentists and dental hygienists that:

(i) increase access to quality, cost effective dental care; and

(ii) use funds from the Division of Family Health and Preparedness that are available to reimburse dentists for educational loans in exchange for the dentist agreeing to serve Medicaid and under-served populations.

(c) The division may amend the state plan and apply to the Secretary of Health and Human Services for waivers or pilot programs if necessary to establish the new dental care delivery and payment reform model. The division shall evaluate the pilot program's effect on the cost of dental care and access to dental care for the targeted Medicaid populations. The division shall report to the Legislature's Health and Human Services Interim Committee by November 30th of each year that the pilot project is in effect.

Amended by Chapter 278, 2013 General Session
Amended by Chapter 278, 2013 General Session

26-18-3. Administration of Medicaid program by department -- Reporting to the Legislature -- Disciplinary measures and sanctions -- Funds collected -- Eligibility standards -- Internal audits -- Studies -- Health opportunity accounts.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) (a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.

(b) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program:

(i) the standards used by the department for determining eligibility for Medicaid services;

(ii) the services and benefits to be covered by the Medicaid program;

(iii) reimbursement methodologies for providers under the Medicaid program; and

(iv) a requirement that:

(A) a person receiving Medicaid services shall participate in the electronic exchange of clinical health records established in accordance with Section 26-1-37 unless the individual opts out of participation;

(B) prior to enrollment in the electronic exchange of clinical health records the enrollee shall receive notice of enrollment in the electronic exchange of clinical health records and the right to opt out of participation at any time; and

(C) beginning July 1, 2012, when the program sends enrollment or renewal information to the enrollee and when the enrollee logs onto the program's website, the enrollee shall receive notice of the right to opt out of the electronic exchange of clinical health records.

(3) (a) The department shall, in accordance with Subsection (3)(b), report to the Social Services Appropriations Subcommittee when the department:

(i) implements a change in the Medicaid State Plan;

(ii) initiates a new Medicaid waiver;

(iii) initiates an amendment to an existing Medicaid waiver;

(iv) applies for an extension of an application for a waiver or an existing Medicaid waiver; or

(v) initiates a rate change that requires public notice under state or federal law.

(b) The report required by Subsection (3)(a) shall:

(i) be submitted to the Social Services Appropriations Subcommittee prior to the department implementing the proposed change; and

(ii) include:

(A) a description of the department's current practice or policy that the

department is proposing to change;

(B) an explanation of why the department is proposing the change;

(C) the proposed change in services or reimbursement, including a description of the effect of the change;

(D) the effect of an increase or decrease in services or benefits on individuals and families;

(E) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and

(F) the fiscal impact of the proposed change, including:

(I) the effect of the proposed change on current or future appropriations from the Legislature to the department;

(II) the effect the proposed change may have on federal matching dollars received by the state Medicaid program;

(III) any cost shifting or cost savings within the department's budget that may result from the proposed change; and

(IV) identification of the funds that will be used for the proposed change, including any transfer of funds within the department's budget.

(4) Any rules adopted by the department under Subsection (2) are subject to review and reauthorization by the Legislature in accordance with Section 63G-3-502.

(5) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including:

(a) the determination of the eligibility of individuals for the program;

(b) recovery of overpayments; and

(c) consistent with Section 26-20-13, and to the extent permitted by law and quality control services, enforcement of fraud and abuse laws.

(6) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(7) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as dedicated credits to be used by the division in accordance with the requirements of Section 1919 of Title XIX of the federal Social Security Act.

(8) (a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department shall, if Subsection (8)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.

(b) Before Subsection (8)(a) may be applied:

(i) the federal government shall:

(A) determine that Subsection (8)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;

(B) extend a waiver to the state permitting the implementation of Subsection (8)(a); or

(C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and

(ii) the department shall determine that Subsection (8)(a) can be implemented within existing funding.

(9) (a) For purposes of this Subsection (9):

(i) "aged, blind, or has a disability" means an aged, blind, or disabled individual, as defined in 42 U.S.C. 1382c(a)(1); and

(ii) "spend down" means an amount of income in excess of the allowable income standard that shall be paid in cash to the department or incurred through the medical services not paid by Medicaid.

(b) In determining whether an applicant or recipient who is aged, blind, or has a disability is eligible for a service or benefit under this chapter, the department shall use 100% of the federal poverty level as:

(i) the allowable income standard for eligibility for services or benefits; and

(ii) the allowable income standard for eligibility as a result of spend down.

(10) The department shall conduct internal audits of the Medicaid program.

(11) In order to determine the feasibility of contracting for direct Medicaid providers for primary care services, the department shall:

(a) issue a request for information for direct contracting for primary services that shall provide that a provider shall exclusively serve all Medicaid clients:

(i) in a geographic area;

(ii) for a defined range of primary care services; and

(iii) for a predetermined total contracted amount; and

(b) by February 1, 2011, report to the Social Services Appropriations Subcommittee on the response to the request for information under Subsection (11)(a).

(12) (a) By December 31, 2010, the department shall:

(i) determine the feasibility of implementing a three year patient-centered medical home demonstration project in an area of the state using existing budget funds; and

(ii) report the department's findings and recommendations under Subsection (12)(a)(i) to the Social Services Appropriations Subcommittee.

(b) If the department determines that the medical home demonstration project described in Subsection (12)(a) is feasible, and the Social Services Appropriations Subcommittee recommends that the demonstration project be implemented, the department shall:

(i) implement the demonstration project; and

(ii) by December 1, 2012, make recommendations to the Social Services Appropriations Subcommittee regarding the:

(A) continuation of the demonstration project;

(B) expansion of the demonstration project to other areas of the state; and

(C) cost savings incurred by the implementation of the demonstration project.

(13) (a) The department may apply for and, if approved, implement a demonstration program for health opportunity accounts, as provided for in 42 U.S.C. Sec. 1396u-8.

(b) A health opportunity account established under Subsection (13)(a) shall be an alternative to the existing benefits received by an individual eligible to receive

Medicaid under this chapter.

(c) Subsection (13)(a) is not intended to expand the coverage of the Medicaid program.

Amended by Chapter 167, 2013 General Session

26-18-3.1. Medicaid expansion.

(1) The purpose of this section is to expand the coverage of the Medicaid program to persons who are in categories traditionally not served by that program.

(2) Within appropriations from the Legislature, the department may amend the state plan for medical assistance to provide for eligibility for Medicaid:

(a) on or after July 1, 1994, for children 12 to 17 years old who live in households below the federal poverty income guideline; and

(b) on or after July 1, 1995, for persons who have incomes below the federal poverty income guideline and who are aged, blind, or have a disability.

(3) (a) Within appropriations from the Legislature, on or after July 1, 1996, the Medicaid program may provide for eligibility for persons who have incomes below the federal poverty income guideline.

(b) In order to meet the provisions of this subsection, the department may seek approval for a demonstration project under 42 U.S.C. Section 1315 from the secretary of the United States Department of Health and Human Services. This demonstration project may also provide for the voluntary participation of private firms that:

(i) are newly established or marginally profitable;

(ii) do not provide health insurance to their employees;

(iii) employ predominantly low wage workers; and

(iv) are unable to obtain adequate and affordable health care insurance in the private market.

(4) Services available for persons described in this section shall include required Medicaid services and may include one or more optional Medicaid services if those services are funded by the Legislature. The department may also require persons described in this section to meet an asset test.

Amended by Chapter 366, 2011 General Session

26-18-3.2. Release of financial information.

(1) (a) Upon request from a hospital, or a designated agent of a hospital, a bank or other financial institution shall provide the hospital, or the designated agent of the hospital, financial records of a patient upon the receipt of a notarized document that includes the following patient information:

(i) name;

(ii) address;

(iii) Social Security number; and

(iv) patient permission to release the information required by this Subsection (1) to the bank or financial institution.

(b) The document required by this Subsection (1) shall be signed by the patient and acknowledged by a notary public.

(2) A hospital, or a designated agent of the hospital, may only request the information required under Subsection (1), if the hospital or the agent of the hospital:

(a) determines that the patient has no ability to pay; and

(b) has received adequate documentation from the patient, such as a valid driver license or passport, to verify the identity of the patient.

Enacted by Chapter 347, 2010 General Session

26-18-3.5. Copayments by recipients -- Employer sponsored plans.

(1) The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

(2) (a) The department shall seek approval under the department's Section 1115 Medicaid waiver to cap enrollment fees for the Primary Care Network Demonstration Project in accordance with Subsection (2)(b).

(b) Pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at $15 per year for those persons who, after July 1, 2003, are eligible to begin receiving General Assistance under Section 35A-3-401.

(c) Beginning July 1, 2004, and pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at $25 per year for those persons who have an income level that is below 50% of the federal poverty level.

(3) Beginning May 1, 2006, within appropriations by the Legislature and as a means to increase health care coverage among the uninsured, the department shall take steps to promote increased participation in employer sponsored health insurance, including:

(a) maximizing the health insurance premium subsidy provided under the state's Primary Care Network Demonstration Project by:

(i) ensuring that state funds are matched by federal funds to the greatest extent allowable; and

(ii) as the department determines appropriate, seeking federal approval to do one or more of the following:

(A) eliminate or otherwise modify the annual enrollment fee;

(B) eliminate or otherwise modify the schedule used to determine the level of subsidy provided to an enrollee each year;

(C) reduce the maximum number of participants allowable under the subsidy program; or

(D) otherwise modify the program in a manner that promotes enrollment in employer sponsored health insurance; and

(b) exploring the use of other options, including the development of a waiver under the Medicaid Health Insurance Flexibility Demonstration Initiative or other federal authority.

Amended by Chapter 148, 2006 General Session

26-18-3.6. Income and resources from institutionalized spouses.

(1) As used in this section:

(a) "Community spouse" means the spouse of an institutionalized spouse.

(b) (i) "Community spouse monthly income allowance" means an amount by which the minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly income otherwise available to the community spouse, determined without regard to the allowance, except as provided in Subsection (1)(b)(ii).

(ii) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse may not be less than the amount of the monthly income so ordered.

(c) "Community spouse resource allowance" is an amount by which the greatest of the following exceeds the amount of the resources otherwise available to the community spouse:

(i) $15,804;

(ii) the lesser of the spousal share computed under Subsection (4) or $76,740;

(iii) the amount established in a hearing held under Subsection (11); or

(iv) the amount transferred by court order under Subsection (11)(c).

(d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal standard utility allowance under SNAP as defined in Section 35A-1-102, exceeds 30% of the amount described in Subsection (9).

(e) "Family member" means a minor dependent child, dependent parents, or dependent sibling of the institutionalized spouse or community spouse who are residing with the community spouse.

(f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility and is married to a spouse who is not in a nursing facility.

(ii) An "institutionalized spouse" does not include a person who is not likely to reside in a nursing facility for at least 30 consecutive days.

(g) "Nursing care facility" is defined in Section 26-21-2.

(2) The division shall comply with this section when determining eligibility for medical assistance for an institutionalized spouse.

(3) For services furnished during a calendar year beginning on or after January 1, 1999, the dollar amounts specified in Subsections (1)(c)(i), (1)(c)(ii), and (10)(b) shall be increased by the division by the amount as determined annually by the federal Health Care Financing Administration.

(4) The division shall compute, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse:

(a) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

(b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).

(5) At the request of an institutionalized spouse or a community spouse, at the

beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the division shall promptly assess and document the total value described in Subsection (4)(a) and shall provide a copy of that assessment and documentation to each spouse and shall retain a copy of the assessment. When the division provides a copy of the assessment, it shall include a notice stating that the spouse may request a hearing under Subsection (11).

(6) When determining eligibility for medical assistance under this chapter:

(a) Except as provided in Subsection (6)(b), all the resources held by either the institutionalized spouse, community spouse, or both, are considered to be available to the institutionalized spouse.

(b) Resources are considered to be available to the institutionalized spouse only to the extent that the amount of those resources exceeds the amounts specified in Subsections (1)(c)(i) through (iv) at the time of application for medical assistance under this chapter.

(7) The division may not find an institutionalized spouse to be ineligible for medical assistance by reason of resources determined under Subsection (5) to be available for the cost of care when:

(a) the institutionalized spouse has assigned to the state any rights to support from the community spouse;

(b) (i) except as provided in Subsection (7)(b)(ii), the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment;

(ii) Subsection (7)(b)(i) does not prevent the division from seeking a court order seeking an assignment of support; or

(c) the division determines that denial of medical assistance would cause an undue burden.

(8) During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is eligible for medical assistance, the resources of the community spouse may not be considered to be available to the institutionalized spouse.

(9) When an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly for the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly income the following amounts in the following order:

(a) a personal needs allowance, the amount of which is determined by the division;

(b) a community spouse monthly income allowance, but only to the extent that the income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

(c) a family allowance for each family member, equal to at least 1/3 of the amount that the amount described in Subsection (10)(a)(i) exceeds the amount of monthly income of that family member; and

(d) amounts for incurred expenses for the medical or remedial care for the institutionalized spouse.

(10) (a) Except as provided in Subsection (10)(b), the division shall establish a minimum monthly maintenance needs allowance for each community spouse which is

not less than the sum of:

(i) 150% of the current poverty guideline for a two-person family unit that applies to this state as established by the United States Department of Health and Human Services; and

(ii) an excess shelter allowance.

(b) The amount provided in Subsection (10)(a) may not exceed $1,976, unless a court order establishes a higher amount.

(11) (a) An institutionalized spouse or a community spouse may request a hearing with respect to the determinations described in Subsections (11)(e)(i) through (v) if an application for medical assistance has been made on behalf of the institutionalized spouse.

(b) A hearing under this subsection regarding the community spouse resource allowance shall be held by the division within 90 days from the date of the request for the hearing.

(c) If either spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance provided under Subsection (10), an amount adequate to provide additional income as is necessary.

(d) If either spouse establishes that the community spouse resource allowance, in relation to the amount of income generated by the allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance, an amount adequate to provide a minimum monthly maintenance needs allowance.

(e) A hearing may be held under this subsection if either the institutionalized spouse or community spouse is dissatisfied with a determination of:

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse;

(iii) the computation of the spousal share of resources under Subsection (4);

(iv) the attribution of resources under Subsection (6); or

(v) the determination of the community spouse resource allocation.

(12) (a) An institutionalized spouse may transfer an amount equal to the community spouse resource allowance, but only to the extent the resources of the institutionalized spouse are transferred to or for the sole benefit of the community spouse.

(b) The transfer under Subsection (12)(a) shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account the time necessary to obtain a court order under Subsection (12)(c).

(c) Chapter 19, Medical Benefits Recovery Act, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

Amended by Chapter 41, 2012 General Session

26-18-3.8. Maximizing use of premium assistance programs -- Utah's

Premium Partnership for Health Insurance.

(1) (a) The department shall seek to maximize the use of Medicaid and Children's Health Insurance Program funds for assistance in the purchase of private health insurance coverage for Medicaid-eligible and non-Medicaid-eligible individuals.

(b) The department's efforts to expand the use of premium assistance shall:

(i) include, as necessary, seeking federal approval under all Medicaid and Children's Health Insurance Program premium assistance provisions of federal law, including provisions of the Patient Protection and Affordable Care Act, Public Law 111-148;

(ii) give priority to, but not be limited to, expanding the state's Utah Premium Partnership for Health Insurance Program, including as required under Subsection (2); and

(iii) encourage the enrollment of all individuals within a household in the same plan, where possible, including enrollment in a plan that allows individuals within the household transitioning out of Medicaid to retain the same network and benefits they had while enrolled in Medicaid.

(c) Any increase in state costs resulting from an expansion of premium assistance may not exceed offsetting reductions in Medicaid and Children's Health Insurance Program state costs attributable to the expansion.

(2) The department shall seek federal approval of an amendment to the state's Utah Premium Partnership for Health Insurance program to adjust the eligibility determination for single adults and parents who have an offer of employer sponsored insurance. The amendment shall:

(a) be within existing appropriations for the Utah Premium Partnership for Health Insurance program; and

(b) provide that adults who are up to 200% of the federal poverty level are eligible for premium subsidies in the Utah Premium Partnership for Health Insurance program.

Amended by Chapter 137, 2013 General Session

26-18-4. Department standards for eligibility under Medicaid -- Funds for abortions.

(1) The department may develop standards and administer policies relating to eligibility under the Medicaid program as long as they are consistent with Subsection 26-18-3(8). An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department may not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.

(4) Any person or organization that, under the guise of other medical treatment,

provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

Amended by Chapter 167, 2013 General Session

26-18-5. Contracts for provision of medical services -- Federal provisions modifying department rules -- Compliance with Social Security Act.

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

(2) All contracts for the provision or purchase of medical services shall be established on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as possible. Contract terms shall include provisions for maintenance, administration, and service costs.

(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation; providing, the provisions of this section do not apply to department rules governing abortion.

(4) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

Amended by Chapter 297, 2011 General Session

26-18-6. Federal aid -- Authority of executive director.

The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department. Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

Enacted by Chapter 126, 1981 General Session

26-18-7. Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

Amended by Chapter 21, 1988 General Session

26-18-8. Enforcement of public assistance statutes.

(1) The department shall enforce or contract for the enforcement of Sections 35A-1-503, 35A-3-108, 35A-3-110, 35A-3-111, 35A-3-112, and 35A-3-603 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.

(2) The department may contract for services covered in Section 35A-3-111 insofar as that section pertains to benefits conferred or administered by the division under this chapter.

Amended by Chapter 90, 2003 General Session

26-18-9. Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

Each state or local employee responsible for the expenditure of funds under the state Medicaid program, each individual who formerly was such an officer or employee, and each partner of such an officer or employee is prohibited for a period of one year after termination of such responsibility from committing any act, the commission of which by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or Section 208 of Title 18, United States Code. Violation of this section is a class A misdemeanor.

Enacted by Chapter 126, 1981 General Session

26-18-10. Utah Medical Assistance Program -- Policies and standards.

(1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.

(2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.

(3) The department shall develop standards and administer policies relating to eligibility requirements, consistent with Subsection 26-18-3(8), for participation in the program, and for payment of medical claims for eligible persons.

(4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.

(5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.

(6) The department may not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the

mother would be endangered if an abortion were not performed.

(7) The department may establish rules to carry out the provisions of this section.

Amended by Chapter 167, 2013 General Session

26-18-11. Rural hospitals.

(1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing may not discriminate among rural hospitals on the basis of size.

Amended by Chapter 297, 2011 General Session

26-18-13. Telemedicine -- Reimbursement -- Rulemaking.

(1) (a) On or after July 1, 2008, communication by telemedicine is considered face to face contact between a health care provider and a patient under the state's medical assistance program if:

(i) the communication by telemedicine meets the requirements of administrative rules adopted in accordance with Subsection (3); and

(ii) the health care services are eligible for reimbursement under the state's medical assistance program.

(b) This Subsection (1) applies to any managed care organization that contracts with the state's medical assistance program.

(2) The reimbursement rate for telemedicine services approved under this section:

(a) shall be subject to reimbursement policies set by the state plan; and

(b) may be based on:

(i) a monthly reimbursement rate;

(ii) a daily reimbursement rate; or

(iii) an encounter rate.

(3) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, which establish:

(a) the particular telemedicine services that are considered face to face encounters for reimbursement purposes under the state's medical assistance program; and

(b) the reimbursement methodology for the telemedicine services designated under Subsection (3)(a).

Enacted by Chapter 41, 2008 General Session

26-18-14. Strategic plan for health system reform -- Medicaid program.

The department, including the Division of Health Care Financing within the department, shall:

(1) work with the Governor's Office of Economic Development, the Insurance Department, the Department of Workforce Services, and the Legislature to develop health system reform in accordance with the strategic plan described in Title 63M, Chapter 1, Part 25, Health System Reform Act;

(2) develop and submit amendments and waivers for the state's Medicaid plan as necessary to carry out the provisions of the Health System Reform Act;

(3) seek federal approval of an amendment to Utah's Premium Partnership for Health Insurance that would allow the state's Medicaid program to subsidize the purchase of health insurance by an individual who does not have access to employer sponsored health insurance;

(4) in coordination with the Department of Workforce Services:

(a) establish a Children's Health Insurance Program eligibility policy, consistent with federal requirements and Subsection 26-40-105(1)(d), that prohibits enrollment of a child in the program if the child's parent qualifies for assistance under Utah's Premium Partnership for Health Insurance; and

(b) involve community partners, insurance agents and producers, community based service organizations, and the education community to increase enrollment of eligible employees and individuals in Utah's Premium Partnership for Health Insurance and the Children's Health Insurance Program; and

(5) as funding permits, and in coordination with the department's adoption of standards for the electronic exchange of clinical health data, help the private sector form an alliance of employers, hospitals and other health care providers, patients, and health insurers to develop and use evidence-based health care quality measures for the purpose of improving health care decision making by health care providers, consumers, and third party payers.

Enacted by Chapter 383, 2008 General Session

26-18-15. Process to promote health insurance coverage for children.

(1) The Department of Workforce Services, the State Board of Education, and the department shall:

(a) collaborate with one another to develop a process to promote health insurance coverage for a child in school when:

(i) the child applies for free or reduced price school lunch;

(ii) a child enrolls in or registers in school; and

(iii) other appropriate school related opportunities;

(b) report to the Legislature on the development of the process under Subsection (1)(a) no later than November 19, 2008; and

(c) implement the process developed under Subsection (1)(a) no later than the 2009-10 school year.

(2) The Department of Workforce Services shall promote and facilitate the enrollment of children identified under Subsection (1)(a) without health insurance in the Utah Children's Health Insurance Program, the Medicaid program, or the Utah Premium Partnership for Health Insurance Program.

Enacted by Chapter 390, 2008 General Session

26-18-16. Medicaid -- Continuous eligibility -- Promoting payment and delivery reform.

(1) In accordance with Subsection (2), and within appropriations from the Legislature, the department may amend the state Medicaid plan to:

(a) create continuous eligibility for up to 12 months for an individual who has qualified for the state Medicaid program;

(b) provide incentives in managed care contracts for an individual to obtain appropriate care in appropriate settings; and

(c) require the managed care system to accept the risk of managing the Medicaid population assigned to the plan amendment in return for receiving the benefits of providing quality and cost effective care.

(2) If the department amends the state Medicaid plan under Subsection (1)(a) or (b), the department:

(a) shall ensure that the plan amendment:

(i) is cost effective for the state Medicaid program;

(ii) increases the quality and continuity of care for recipients; and

(iii) calculates and transfers administrative savings from continuous enrollment from the Department of Workforce Services to the Department of Health; and

(b) may limit the plan amendment under Subsection (1)(a) or (b) to select geographic areas or specific Medicaid populations.

(3) The department may seek approval for a state plan amendment, waiver, or a demonstration project from the Secretary of Health and Human Services if necessary to implement a plan amendment under Subsection (1)(a) or (b).

Enacted by Chapter 155, 2012 General Session

26-18-17. Patient notice of health care provider privacy practices.

(1) (a) For purposes of this section:

(i) "Health care provider" means a health care provider as defined in Section 78B-3-403 who:

(A) receives payment for medical services from the Medicaid program established in this chapter, or the Children's Health Insurance Program established in Chapter 40, Utah Children's Health Insurance Act; and

(B) submits a patient's personally identifiable information to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database.

(ii) "HIPAA" means 45 C.F.R. Parts 160, 162, and 164, Health Insurance Portability and Accountability Act of 1996, as amended.

(b) Beginning July 1, 2013, this section applies to the Medicaid program, the Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act, and a health care provider.

(2) A health care provider shall, as part of the notice of privacy practices required by HIPAA, provide notice to the patient or the patient's personal representative that the health care provider either has, or may submit, personally identifiable information about the patient to the Medicaid eligibility database and the Children's Health Insurance Program eligibility database.

(3) The Medicaid program and the Children's Health Insurance Program may not

give a health care provider access to the Medicaid eligibility database or the Children's Health Insurance Program eligibility database unless the health care provider's notice of privacy practices complies with Subsection (2).

(4) The department may adopt an administrative rule to establish uniform language for the state requirement regarding notice of privacy practices to patients required under Subsection (2).

Enacted by Chapter 53, 2013 General Session

26-18-18. Optional Medicaid expansion.

(1) For purposes of this section PPACA is as defined in Section 31A-1-301.

(2) The department and the governor shall not expand the state's Medicaid program to the optional population under PPACA unless:

(a) the Health Reform Task Force has completed a thorough analysis of a statewide charity care system;

(b) the department and its contractors have:

(i) completed a thorough analysis of the impact to the state of expanding the state's Medicaid program to optional populations under PPACA; and

(ii) made the analysis conducted under Subsection (2)(b)(i) available to the public;

(c) the governor or the governor's designee has reported the intention to expand the state Medicaid program under PPACA to the Legislature in compliance with the legislative review process in Sections 63M-1-2505.5 and 26-18-3; and

(d) notwithstanding Subsection 63J-5-103(2), the governor submits the request for expansion of the Medicaid program for optional populations to the Legislature under the high impact federal funds request process required by Section 63J-5-204, Legislative review and approval of certain federal funds request.

Enacted by Chapter 477, 2013 General Session

26-18-19. Medicaid vision services -- Request for proposals.

The department may select one or more contractors in accordance with Title 63G, Chapter 6a, Utah Procurement Code, to provide vision services to all Medicaid populations without restricting provider participation, and within existing appropriations from the Legislature.

Enacted by Chapter 366, 2013 General Session

26-18-101. Definitions.

As used in this part:

(1) "Appropriate and medically necessary" means, regarding drug prescribing, dispensing, and patient usage, that it is in conformity with the criteria and standards developed in accordance with this part.

(2) "Board" means the Drug Utilization Review Board created in Section 26-18-102.

(3) "Compendia" means resources widely accepted by the medical profession in

the efficacious use of drugs, including "American Hospital Formulary Services Drug Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations," peer-reviewed medical literature, and information provided by manufacturers of drug products.

(4) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the board under this part.

(5) "Criteria" means those predetermined and explicitly accepted elements used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(6) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.

(7) "Drug-interactions" means that two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present, or that leads to interference with the effectiveness of one or any of the drugs.

(8) "Drug Utilization Review" or "DUR" means the program designed to measure and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the Medicaid program.

(9) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(10) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.

(11) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17b, Pharmacy Practice Act.

(12) "Physician" means a person licensed in this state to practice medicine and surgery under Section 58-67-301 or osteopathic medicine under Section 58-68-301.

(13) "Prospective DUR" means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and predetermined criteria and standards.

(14) "Retrospective DUR" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.

(15) "Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.

(16) "SURS" means the Surveillance Utilization Review System of the Medicaid program.

(17) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.

(18) "Therapeutic duplication" means prescribing and dispensing the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.

Amended by Chapter 280, 2004 General Session

26-18-102. DUR Board -- Creation and membership -- Expenses.

(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.

(2) (a) Except as required by Subsection (2)(b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (2)(a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.

(d) The executive director shall provide for geographic balance in representation on the board.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(4) The membership shall be comprised of the following:

(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;

(b) one physician in this state who is actively engaged in academic medicine;

(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;

(d) one pharmacist who is actively engaged in academic pharmacy;

(e) one person who shall represent consumers;

(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and

(g) one dentist licensed to practice in this state under Title 58, Chapter 69, Dentists and Dental Hygienists Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.

(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.

(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.

(7) A member may not receive compensation or benefits for the member's service, but may receive per diem and travel expenses in accordance with:

(a) Section 63A-3-106;

(b) Section 63A-3-107; and

(c) rules made by the Division of Finance pursuant to Sections 63A-3-106 and 63A-3-107.

Amended by Chapter 286, 2010 General Session
Amended by Chapter 324, 2010 General Session

26-18-103. DUR Board -- Responsibilities.

The board shall:

(1) develop rules necessary to carry out its responsibilities as defined in this part;

(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;

(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) therapeutic duplication;

(d) drug-disease contraindications;

(e) drug-drug interactions;

(f) incorrect drug dosage or duration of drug treatment; and

(g) clinical abuse and misuse;

(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;

(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;

(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;

(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;

(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;

(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;

(11) publish an annual report, subject to public comment prior to its issuance, and submit that report to the United States Department of Health and Human Services by December 1 of each year. That report shall also be submitted to the executive director, the president of the Utah Pharmaceutical Association, and the president of the Utah Medical Association by December 1 of each year. The report shall include:

(a) an overview of the activities of the board and the DUR program;

(b) a description of interventions used and their effectiveness, specifying whether the intervention was a result of underutilization or overutilization of drugs, without disclosing the identities of individual physicians, pharmacists, or recipients;

(c) the costs of administering the DUR program;

(d) any fiscal savings resulting from the DUR program;

(e) an overview of the fiscal impact of the DUR program to other areas of the Medicaid program such as hospitalization or long-term care costs;

(f) a quantifiable assessment of whether DUR has improved the recipient's quality of care;

(g) a review of the total number of prescriptions, by drug therapeutic class;

(h) an assessment of the impact of educational programs or interventions on prescribing or dispensing practices; and

(i) recommendations for DUR program improvement;

(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;

(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63G, Chapter 4, Administrative Procedures Act;

(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:

(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;

(b) potential or actual severe or adverse reactions to drugs;

(c) therapeutic appropriateness;

(d) overutilization or underutilization;

(e) appropriate use of generics;

(f) therapeutic duplication;

(g) drug-disease contraindications;

(h) drug-drug interactions;

(i) incorrect drug dosage and duration of drug treatment;

(j) drug allergy interactions; and

(k) clinical abuse and misuse;

(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:

(a) the name and description of the medication;

(b) administration, form, and duration of therapy;

(c) special directions and precautions for use;

(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;

(e) techniques for self-monitoring drug therapy;

(f) proper storage;
(g) prescription refill information; and
(h) action to be taken in the event of a missed dose; and
(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:
(a) the name, address, age, and gender of the recipient;
(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;
(c) the pharmacist's comments on the individual's drug therapy;
(d) name of prescriber; and
(e) name of drug, dose, duration of therapy, and directions for use.

Amended by Chapter 167, 2013 General Session

26-18-104. Confidentiality of records.

(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63G, Chapter 2, Government Records Access and Management Act.
(2) The board shall establish procedures insuring that the information described in Subsection 26-18-103(16) is held confidential by the pharmacist, being provided to the physician only upon request.
(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

Amended by Chapter 382, 2008 General Session

26-18-105. Drug prior approval program.

(1) A drug prior approval program approved or implemented by the board shall meet the following conditions:
(a) except as provided in Subsection (2), a drug may not be placed on prior approval for other than medical reasons;
(b) the board shall hold a public hearing at least 30 days prior to placing a drug on prior approval;
(c) notwithstanding the provisions of Section 52-4-202, the board shall provide not less than 14 days' notice to the public before holding a public hearing under Subsection (1)(b);
(d) the board shall consider written and oral comments submitted by interested parties prior to or during the hearing held in accordance with Subsection (1)(b);

(e) the board shall provide evidence that placing a drug class on prior approval:
(i) will not impede quality of recipient care; and
(ii) that the drug class is subject to clinical abuse or misuse;
(f) the board shall reconsider its decision to place a drug on prior approval:
(i) no later than nine months after any drug class is placed on prior approval; and
(ii) at a public hearing with notice as provided in Subsection (1)(b);
(g) the program shall provide an approval or denial of a request for prior approval:
(i) by either:
(A) fax;
(B) telephone; or
(C) electronic transmission;
(ii) at least Monday through Friday, except for state holidays; and
(iii) within 24 hours after receipt of the prior approval request;
(h) the program shall provide for the dispensing of at least a 72-hour supply of the drug on the prior approval program:
(i) in an emergency situation; or
(ii) on weekends or state holidays;
(i) the program may be applied to allow acceptable medical use of a drug on prior approval for appropriate off-label indications; and
(j) before placing a drug class on the prior approval program, the board shall:
(i) determine that the requirements of Subsections (1)(a) through (i) have been met; and
(ii) by majority vote, place the drug class on prior approval.
(2) The board may, only after complying with Subsections (1)(b) through (j), consider the cost:
(a) of a drug when placing a drug on the prior approval program; and
(b) associated with including, or excluding a drug from the prior approval process, including:
(i) potential side effects associated with a drug; or
(ii) potential hospitalizations or other complications that may occur as a result of a drug's inclusion on the prior approval process.

Amended by Chapter 205, 2010 General Session

26-18-106. Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under this part.

Enacted by Chapter 273, 1992 General Session

26-18-107. Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically

necessary, and not likely to result in adverse medical outcomes.

(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).

(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:

(a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and

(b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:

(i) therapeutic appropriateness;

(ii) overutilization or underutilization;

(iii) therapeutic duplication;

(iv) drug-disease contraindications;

(v) drug-drug interactions;

(vi) incorrect drug dosage or duration of drug treatment; and

(vii) clinical abuse and misuse.

(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) therapeutic duplication;

(b) drug-drug interactions;

(c) incorrect dosage or duration of treatment;

(d) drug-allergy interactions; and

(e) clinical abuse or misuse.

(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

Enacted by Chapter 273, 1992 General Session

26-18-108. Penalties.

Any person who violates the confidentiality provisions of this part is guilty of a class B misdemeanor.

Enacted by Chapter 273, 1992 General Session

26-18-109. Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of this part.

Enacted by Chapter 273, 1992 General Session

26-18-402. Medicaid Restricted Account.

(1) There is created a restricted account in the General Fund known as the Medicaid Restricted Account.

(2) (a) Except as provided in Subsection (3), the following shall be deposited into the Medicaid Restricted Account:

(i) any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account;

(ii) any unused state funds that are associated with the Medicaid program, as defined in Section 26-18-2, from the Department of Workforce Services and the Department of Human Services; and

(iii) any penalties imposed and collected under:

(A) Section 17B-2a-818.5;

(B) Section 19-1-206;

(C) Section 63A-5-205;

(D) Section 63C-9-403;

(E) Section 72-6-107.5; or

(F) Section 79-2-404.

(b) The account shall earn interest and all interest earned shall be deposited into the account.

(c) The Legislature may appropriate money in the restricted account to fund programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40.

(3) For fiscal years 2008-09, 2009-10, 2010-11, 2011-12, and 2012-13 the following funds are nonlapsing:

(a) any general funds appropriated to the department for the state plan for medical assistance, or for the Division of Health Care Financing that are not expended by the department in the fiscal year in which the general funds were appropriated; and

(b) funds described in Subsection (2)(a)(ii).

Amended by Chapter 278, 2013 General Session

26-18-403. Medicaid waiver for independent foster care adolescents.

(1) For purposes of this section, an "independent foster care adolescent" includes any individual who reached 18 years of age while in the custody of the Division of Child and Family Services, or the Department of Human Services if the Division of Child and Family Services was the primary case manager, or a federally recognized Indian tribe.

(2) An independent foster care adolescent is eligible, when funds are available, for Medicaid coverage until the individual reaches 21 years of age.

(3) Before July 1, 2006, the division shall submit a state Medicaid Plan amendment to the Center For Medicaid Services to provide medical coverage for independent foster care adolescents effective fiscal year 2006-07.

Enacted by Chapter 110, 2006 General Session

26-18-404. Home and community-based long-term care -- Room and board assistance.

If the department receives approval from the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services to replace the Medicaid program's current FlexCare program with a new program to provide long-term care services in home and community-based settings rather than institutions, the department shall assist in the payment of room and board costs for any person in the new program without sufficient income to fully pay those costs.

Enacted by Chapter 190, 2007 General Session

26-18-405. Waivers to maximize replacement of fee-for-service delivery model.

(1) The department shall develop a proposal to amend the state plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models.

(2) The proposal shall:

(a) restructure the program's provider payment provisions to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that, compared to services delivered before implementation of the proposal, maintain or improve recipient health status;

(b) restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to:

(i) maintain or improve their health status; and

(ii) use providers that deliver the most appropriate services at the lowest cost;

(c) identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that:

(i) pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and

(ii) reward providers for delivering services that make the most positive contribution to a recipient's health status;

(d) limit total annual per-patient-per-month expenditures for services delivered through fee-for-service arrangements to total annual per-patient-per-month expenditures for services delivered through risk-based arrangements covering similar recipient populations and services; and

(e) limit the rate of growth in per-patient-per-month General Fund expenditures for the program to the rate of growth in General Fund expenditures for all other programs, when the rate of growth in the General Fund expenditures for all other programs is greater than zero.

(3) To the extent possible, the department shall develop the proposal with the input of stakeholder groups representing those who will be affected by the proposal.

(4) No later than June 1, 2011, the department shall submit a written report on the development of the proposal to the Legislature's Executive Appropriations Committee, Social Services Appropriations Subcommittee, and Health and Human Services Interim Committee.

(5) No later than July 1, 2011, the department shall submit to the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services a request for waivers from federal statutory and regulatory law necessary to implement the proposal.

(6) After the request for waivers has been made, and prior to its implementation, the department shall report to the Legislature in accordance with Section 26-18-3 on any modifications to the request proposed by the department or made by the Centers for Medicare and Medicaid Services.

(7) The department shall implement the proposal in the fiscal year that follows the fiscal year in which the United States Secretary of Health and Human Services approves the request for waivers.

Enacted by Chapter 211, 2011 General Session

26-18-406. Medicaid waiver for community service pilot program.

(1) For purposes of this section, "community service pilot program" is a program in which the department:

(a) identifies less than 100 Medicaid recipients who are capable of providing community services to others;

(b) exempts a Medicaid recipient who is not capable of providing community services from the requirements of the community service pilot program;

(c) identifies community services that the department will recognize for purposes of the pilot program; and

(d) requires an individual identified under Subsection (1)(a) who is receiving Medicaid services to perform a certain number of hours of community service as a condition of receiving Medicaid benefits.

(2) The department shall develop a proposal to amend the state Medicaid plan to include a community service pilot program.

(3) The department shall, by January 1, 2012, apply for a Medicaid waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement a community service pilot program within the state Medicaid plan.

Amended by Chapter 167, 2013 General Session

26-18-407. Medicaid waiver for autism spectrum disorder.

(1) As used in this section:

(a) "Autism spectrum disorder" is as defined by the most recent edition of the Diagnostic and Statistical Manual on Mental Disorders or a recent edition of a professionally accepted diagnostic manual.

(b) "Program" means the autism spectrum disorder program created in Subsection (3).

(c) "Qualified child" means a child who is:

(i) at least two years of age but less than seven years of age; and

(ii) diagnosed with an autism spectrum disorder by a qualified professional.

(2) The department shall apply for a Medicaid waiver with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to implement, within the state Medicaid program, the program described in Subsection (3).

(3) The department shall offer an autism spectrum disorder program that:

(a) as funding permits, provides treatment for autism spectrum disorders to qualified children; and

(b) accepts applications for the program during periods of open enrollment.

(4) The department shall:

(a) convene a public process with the Department of Human Services to determine the benefits and services the program shall offer qualified children that considers, in addition to any other relevant factor:

(i) demonstrated effective treatments;

(ii) methods to engage family members in the treatment process; and

(iii) outreach to qualified children in rural and underserved areas of the state; and

(b) evaluate the ongoing results, cost, and effectiveness of the program.

(5) The department shall annually report to the Legislature's Health and Human Services Interim Committee before each November 30 while the waiver is in effect regarding:

(a) the number of qualified children served under the waiver;

(b) success involving families in supporting treatment plans for autistic children;

(c) the cost of the program; and

(d) the results and effectiveness of the program.

Amended by Chapter 302, 2014 General Session

26-18-408. Incentives to appropriately use emergency room services.

(1) (a) This section applies to the Medicaid program and to the Utah Children's Health Insurance Program created in Chapter 40, Utah Children's Health Insurance Act.

(b) For purposes of this section:

(i) "Accountable care organization" means a Medicaid or Children's Health Insurance Program administrator that contracts with the Medicaid program or the Children's Health Insurance Program to deliver health care through an accountable care plan.

(ii) "Accountable care plan" means a risk based delivery service model authorized by Section 26-18-405 and administered by an accountable care organization.

(iii) "Nonemergent care":

(A) means use of the emergency room to receive health care that is nonemergent as defined by the department by administrative rule adopted in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act and the Emergency Medical Treatment and Active Labor Act; and

(B) does not mean the medical services provided to a recipient to conduct a medical screening examination to determine if the recipient has an emergent or nonemergent condition.

(2) (a) An accountable care organization may, in accordance with Subsection (2)(b):

(i) audit emergency room services provided to a recipient enrolled in the accountable care plan to determine if nonemergent care was provided to the recipient; and

(ii) establish differential payment for emergent and nonemergent care provided in an emergency room.

(b) (i) The audits and differential payments under Subsections (2)(a) and (b) apply to services provided to a recipient on or after July 1, 2015.

(ii) Except in cases of suspected fraud, waste, and abuse, an accountable care organization's audit of payment under Subsections (2)(a) and (b) is limited to the 18-month period of time after the date on which the medical services were provided to the recipient. If fraud, waste, or abuse is alleged, the accountable care organization's audit of payment under Subsections (2)(a) and (b) is limited to three years after the date on which the medical services were provided to the recipient.

(3) An accountable care organization shall:

(a) use the savings under Subsection (2) to maintain and improve access to primary care and urgent care services for all of the recipients enrolled in the accountable care plan; and

(b) report to the department on how the accountable care organization complied with Subsection (3)(a).

(4) (a) The department shall, through administrative rule adopted by the department, develop quality measurements that evaluate an accountable care organization's delivery of:

(i) appropriate emergency room services to recipients enrolled in the accountable care plan;

(ii) expanded primary care and urgent care for recipients enrolled in the accountable care plan, with consideration of the accountable care organization's:

(A) emergency room diversion plans;

(B) recipient access to primary care providers and community health centers including evening and weekend access; and

(C) other innovations for expanding access to primary care; and

(iii) quality of care for the accountable care plan members.

(b) The department shall:

(i) compare the quality measures developed under Subsection (4)(a) for each accountable care organization; and

(ii) share the data and quality measures developed under Subsection (4)(a) with the Health Data Committee created in Chapter 33a, Utah Health Data Authority Act.

(c) The Health Data Committee may publish data in accordance with Chapter 33a, Utah Health Data Authority Act which compares the quality measures for the accountable care plans.

(5) The department shall apply for a Medicaid waiver and a Children's Health Insurance Program waiver with the Centers for Medicare and Medicaid Services within

the United States Department of Health and Human Services, to:

(a) allow the program to charge recipients who are enrolled in an accountable care plan a higher copayment for emergency room services; and

(b) develop, by administrative rule, an algorithm to determine assignment of new, unassigned recipients to specific accountable care plans based on the plan's performance in relation to the quality measures developed pursuant to Subsection (4)(a).

(6) The department shall report to the Legislature's Health and Human Services Interim Committee on or before October 1, 2016, regarding implementation of this section.

Enacted by Chapter 103, 2013 General Session

26-18-409. Long-term care insurance partnership.

(1) As used in this section:

(a) "Qualified long-term care insurance contract" is as defined in 26 U.S.C. Sec. 7702B(b).

(b) "Qualified long-term care insurance partnership" is as defined in 42 U.S.C. Sec. 1396p(b)(iii).

(c) "State plan amendment" means an amendment to the state Medicaid plan drafted by the department in compliance with this section.

(2) No later than July 1, 2014, the department shall seek federal approval of a state plan amendment that creates a qualified long-term care insurance partnership.

(3) The department may make rules to comply with federal laws and regulations relating to qualified long-term care insurance partnerships and qualified long-term care insurance contracts.

Enacted by Chapter 174, 2014 General Session

26-18-501. Definitions.

As used in this part:

(1) "Certified program" means a nursing care facility program with Medicaid certification.

(2) "Director" means the director of the Division of Health Care Financing.

(3) "Medicaid certification" means the right to Medicaid reimbursement as a provider of a nursing care facility program as established by division rule.

(4) (a) "Nursing care facility" means the following facilities licensed by the department under Chapter 21, Health Care Facility Licensing and Inspection Act:

(i) skilled nursing homes;

(ii) intermediate care facilities; and

(iii) an intermediate care facility for people with an intellectual disability.

(b) "Nursing care facility" does not mean a critical access hospital that meets the criteria of 42 U.S.C. 1395i-4(c)(2) (1998).

(5) "Nursing care facility program" means the personnel, licenses, services, contracts and all other requirements that shall be met for a nursing care facility to be eligible for Medicaid certification under this part and division rule.

(6) "Physical facility" means the buildings or other physical structures where a nursing care facility program is operated.

(7) "Service area" means the boundaries of the distinct geographic area served by a certified program as determined by the division in accordance with this part and division rule.

Amended by Chapter 297, 2011 General Session
Amended by Chapter 366, 2011 General Session

26-18-502. Purpose -- Medicaid certification of nursing care facilities.

(1) The Legislature finds:

(a) that an oversupply of nursing care facility programs in the state adversely affects the state Medicaid program and the health of the people in the state; and

(b) it is in the best interest of the state to prohibit Medicaid certification of nursing care facility programs, except as authorized by this part.

(2) Medicaid reimbursement of nursing care facility programs is limited to:

(a) the number of nursing care facility programs with Medicaid certification as of May 4, 2004; and

(b) additional nursing care facility programs approved for Medicaid certification under the provisions of Subsections 26-18-503(5) and (7).

(3) The division may not:

(a) except as authorized by Section 26-18-503:

(i) process initial applications for Medicaid certification or execute provider agreements with nursing care facility programs; or

(ii) reinstate Medicaid certification for a nursing care facility whose certification expired or was terminated by action of the federal or state government; or

(b) execute a Medicaid provider agreement with a certified program that moves its nursing care facility program to a different physical facility, except as authorized by Subsection 26-18-503(3).

Amended by Chapter 60, 2013 General Session

26-18-503. Authorization to renew, transfer, or increase Medicaid certified programs -- Reimbursement methodology.

(1) (a) The division may renew Medicaid certification of a certified program if the program, without lapse in service to Medicaid recipients, has its nursing care facility program certified by the division at the same physical facility as long as the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) The division may renew Medicaid certification of a nursing care facility program that is not currently certified if:

(i) since the day on which the program last operated with Medicaid certification:

(A) the physical facility where the program operated has functioned solely and continuously as a nursing care facility; and

(B) the owner of the program has not, under this section or Section 26-18-505, transferred to another nursing care facility program the license for any of the Medicaid

beds in the program; and

(ii) the number of beds granted renewed Medicaid certification does not exceed the number of beds certified at the time the program last operated with Medicaid certification, excluding a period of time where the program operated with temporary certification under Subsection 26-18-504(4).

(2) (a) The division may issue a Medicaid certification for a new nursing care facility program if a current owner of the Medicaid certified program transfers its ownership of the Medicaid certification to the new nursing care facility program and the new nursing care facility program meets all of the following conditions:

(i) the new nursing care facility program operates at the same physical facility as the previous Medicaid certified program;

(ii) the new nursing care facility program gives a written assurance to the director in accordance with Subsection (4);

(iii) the new nursing care facility program receives the Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient; and

(iv) the licensed and certified bed capacity at the facility has not been expanded, unless the director has approved additional beds in accordance with Subsection (5).

(b) A nursing care facility program that receives Medicaid certification under the provisions of Subsection (2)(a) does not assume the Medicaid liabilities of the previous nursing care facility program if the new nursing care facility program:

(i) is not owned in whole or in part by the previous nursing care facility program; or

(ii) is not a successor in interest of the previous nursing care facility program.

(3) The division may issue a Medicaid certification to a nursing care facility program that was previously a certified program but now resides in a new or renovated physical facility if the nursing care facility program meets all of the following:

(a) the nursing care facility program met all applicable requirements for Medicaid certification at the time of closure;

(b) the new or renovated physical facility is in the same county or within a five-mile radius of the original physical facility;

(c) the time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years;

(d) if Subsection (3)(c) applies, the certified program notifies the department within 90 days after ceasing operations in its original facility, of its intent to retain its Medicaid certification;

(e) the provider gives written assurance to the director in accordance with Subsection (4) that no third party has a legitimate claim to operate a certified program at the previous physical facility; and

(f) the bed capacity in the physical facility has not been expanded unless the director has approved additional beds in accordance with Subsection (5).

(4) (a) The entity requesting Medicaid certification under Subsections (2) and (3) shall give written assurances satisfactory to the director or the director's designee that:

(i) no third party has a legitimate claim to operate the certified program;

(ii) the requesting entity agrees to defend and indemnify the department against

any claims by a third party who may assert a right to operate the certified program; and

(iii) if a third party is found, by final agency action of the department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the physical facility the certified program shall voluntarily comply with Subsection (4)(b).

(b) If a finding is made under the provisions of Subsection (4)(a)(iii):

(i) the certified program shall immediately surrender its Medicaid certification and comply with division rules regarding billing for Medicaid and the provision of services to Medicaid patients; and

(ii) the department shall transfer the surrendered Medicaid certification to the third party who prevailed under Subsection (4)(a)(iii).

(5) (a) As provided in Subsection 26-18-502(2)(b), the director shall issue additional Medicaid certification when requested by a nursing care facility or other interested party if there is insufficient bed capacity with current certified programs in a service area. A determination of insufficient bed capacity shall be based on the nursing care facility or other interested party providing reasonable evidence of an inadequate number of beds in the county or group of counties impacted by the requested Medicaid certification based on:

(i) current demographics which demonstrate nursing care facility occupancy levels of at least 90% for all existing and proposed facilities within a prospective three-year period;

(ii) current nursing care facility occupancy levels of 90%; or

(iii) no other nursing care facility within a 35-mile radius of the nursing care facility requesting the additional certification.

(b) In addition to the requirements of Subsection (5)(a), a nursing care facility program shall demonstrate by an independent analysis that the nursing care facility can financially support itself at an after tax break-even net income level based on projected occupancy levels.

(c) When making a determination to certify additional beds or an additional nursing care facility program under Subsection (5)(a):

(i) the director shall consider whether the nursing care facility will offer specialized or unique services that are underserved in a service area;

(ii) the director shall consider whether any Medicaid certified beds are subject to a claim by a previous certified program that may reopen under the provisions of Subsections (2) and (3); and

(iii) the director may consider how to add additional capacity to the long-term care delivery system to best meet the needs of Medicaid recipients.

(6) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adjust the Medicaid nursing care facility property reimbursement methodology to:

(a) beginning July 1, 2008, only pay that portion of the property component of rates, representing actual bed usage by Medicaid clients as a percentage of the greater of:

(i) actual occupancy; or

(ii) (A) for a nursing care facility other than a facility described in Subsection (6)(a)(ii)(B), 85% of total bed capacity; or

(B) for a rural nursing care facility, 65% of total bed capacity; and

(b) beginning July 1, 2008, not allow for increases in reimbursement for property values without major renovation or replacement projects as defined by the department by rule.

(7) (a) Notwithstanding Subsection 26-18-504(4), if a nursing care facility does not seek Medicaid certification for a bed under the provisions of Subsections (1) through (6), the department shall grant Medicaid certification for a licensed non-Medicaid certified bed if:

(i) the nursing care facility is licensed under Subsection 26-21-23(2)(b);

(ii) the nursing care facility meets the quality of care regulations issued by the Center for Medicare and Medicaid Services;

(iii) the Medicaid certified bed will be used by a patient who:

(A) is a resident of the nursing care facility;

(B) has exhausted the patient's Medicare benefits for skilled nursing services; and

(C) qualifies for Medicaid; and

(iv) the total number of licensed beds in the facility that are granted Medicaid certification under the provisions of this Subsection (7)(a) does not exceed 10% of the total number of licensed beds in the facility.

(b) The department may not revoke the Medicaid certification of a bed under this Subsection (7) as long as the provisions of Subsections (7)(a)(ii) and (iii) are met.

Amended by Chapter 60, 2013 General Session

26-18-504. Appeals of division decision -- Rulemaking authority -- Application of act.

(1) A decision by the director under this part to deny Medicaid certification for a nursing care facility program or to deny additional bed capacity for an existing certified program is subject to review under the procedures and requirements of Title 63G, Chapter 4, Administrative Procedures Act.

(2) The department shall make rules to administer and enforce this part in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) A nursing care facility may receive Medicaid certification under the rules in effect prior to July 1, 2004 if the nursing care facility, prior to May 4, 2004:

(a) (i) paid applicable fees to the department; and

(ii) submits construction plans to the department; or

(b) is in a current phase of construction approved by the department.

(4) (a) In the event the department is at risk for a federal disallowance with regard to a Medicaid recipient being served in a nursing care facility program that is not Medicaid certified, the department may grant temporary Medicaid certification to that facility for up to 24 months.

(b) (i) The department may extend a temporary Medicaid certification granted to a facility under Subsection (4)(a):

(A) for the number of beds in the nursing care facility occupied by a Medicaid recipient; and

(B) for the period of time during which the Medicaid recipient resides at the

facility.

(ii) A temporary Medicaid certification granted under this Subsection (4) is revoked upon:

(A) the discharge of the patient from the facility; or

(B) the patient no longer residing at the facility for any reason.

(c) The department may place conditions on the temporary certification granted under Subsections (4)(a) and (b), such as:

(i) not allowing additional admissions of Medicaid recipients to the program; and

(ii) not paying for the care of the patient after October 1, 2008, with state only dollars.

Amended by Chapter 347, 2008 General Session
Amended by Chapter 382, 2008 General Session

26-18-505. Authorization to sell or transfer licensed Medicaid beds -- Duties of transferor -- Duties of transferee -- Duties of division.

(1) This section provides a method to transfer the license for a Medicaid bed from one nursing care facility program to another entity that is in addition to the authorization to transfer under Section 26-18-503.

(2) (a) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds in accordance with Subsection (2)(b) if:

(i) at the time of the transfer, and with respect to the license for the Medicaid bed that will be transferred, the nursing care facility program that will transfer the Medicaid license meets all applicable regulations for Medicaid certification;

(ii) 30 days prior to the transfer, the nursing care facility program gives a written assurance to the director and to the transferee in accordance with Subsection 26-18-503(4); and

(iii) 30 days prior to the transfer, the nursing care facility program that will transfer the license for a Medicaid bed notifies the division in writing of:

(A) the number of bed licenses that will be transferred;

(B) the date of the transfer; and

(C) the identity and location of the entity receiving the transferred licenses.

(b) A nursing care facility program may transfer or sell one or more of its licenses for Medicaid beds to:

(i) a nursing care facility program that has the same owner or successor in interest of the same owner;

(ii) a nursing care facility program that has a different owner; or

(iii) an entity that intends to establish a nursing care facility program.

(3) An entity that receives or purchases a license for a Medicaid bed:

(a) may receive a license for a Medicaid bed from more than one nursing care facility program;

(b) within 14 days of seeking Medicaid certification of beds in the nursing care facility program, give the division notice of the total number of licenses for Medicaid beds that the entity received and who it received the licenses from;

(c) may only seek Medicaid certification for the number of licensed beds in the nursing care facility program equal to the total number of licenses for Medicaid beds

received by the entity, multiplied by a conversion factor of .7, and rounded down to the lowest integer;

(d) does not have to demonstrate need for the Medicaid licensed beds under Subsection 26-18-503(5);

(e) shall meet the standards for Medicaid certification other than those in Subsection 26-18-503(5), including personnel, services, contracts, and licensing of facilities under Chapter 21, Health Care Facility Licensing and Inspection Act; and

(f) shall obtain Medicaid certification for the licensed Medicaid beds within three years of the date of transfer as documented under Subsection (2)(a)(iii)(B).

(4) The conversion formula required by Subsection (3)(c) shall be calculated:

(a) when the nursing care facility program applies to the Department for Medicaid certification of the licensed beds; and

(b) based on the total number of licenses for Medicaid beds transferred to the nursing care facility at the time of the request for Medicaid certification.

(5) (a) When the division receives notice of a transfer of a license for a Medicaid bed under Subsection (2)(a)(iii)(A), the division shall reduce the number of licenses for Medicaid beds at the transferring nursing care facility:

(i) equal to the number of licenses transferred; and

(ii) effective on the date of the transfer as reported under Subsection (2)(a)(iii)(B).

(b) For purposes of Section 26-18-502, the division shall approve Medicaid certification for the receiving entity:

(i) in accordance with the formula established in Subsection (3)(c); and

(ii) if:

(A) the nursing care facility seeks Medicaid certification for the transferred licenses within the time limit required by Subsection (3)(f); and

(B) the nursing care facility program meets other requirements for Medicaid certification under Subsection (3)(e).

(c) A license for a Medicaid bed may not be approved for Medicaid certification without meeting the requirements of Sections 26-18-502 and 26-18-503 if:

(i) the license for a Medicaid bed is transferred under this section but the receiving entity does not obtain Medicaid certification for the licensed bed within the time required by Subsection (3)(f); or

(ii) the license for a Medicaid bed is transferred under this section but the license is no longer eligible for Medicaid certification as a result of the conversion factor established in Subsection (3)(c).

Amended by Chapter 297, 2011 General Session

26-18-601. Title.

This part is known as "Medical Assistance Accountability."

Enacted by Chapter 362, 2011 General Session

26-18-602. Definitions.

As used in this part:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs or other medical or hospital assistance costs; or

(b) reckless or negligent upcoding.

(2) "Auditor's Office" means the Office of Internal Audit and Program Integrity, within the department.

(3) "Fraud" means intentional or knowing:

(a) deception, misrepresentation, or upcoding in relation to Medicaid funds, costs, claims, reimbursement, or practice; or

(b) deception or misrepresentation in relation to medical or hospital assistance funds, costs, claims, reimbursement, or practice.

(4) "Medical or hospital assistance" is as defined in Section 26-18-2.

(5) "Upcoding" means assigning an inaccurate billing code for a service that is payable or reimbursable by Medicaid funds, if the correct billing code for the service, taking into account reasonable opinions derived from official published coding definitions, would result in a lower Medicaid payment or reimbursement.

(6) "Waste" means overutilization of resources or inappropriate payment.

Enacted by Chapter 362, 2011 General Session

26-18-603. Adjudicative proceedings related to Medicaid funds.

(1) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to recovery of Medicaid funds:

(a) the presiding officer shall be designated by the executive director of the department and report directly to the executive director or, in the discretion of the executive director, report directly to the director of the Office of Internal Audit and Program Integrity; and

(b) the decision of the presiding officer is the recommended decision to the executive director of the department or a designee of the executive director who is not in the division.

(2) Subsection (1) does not apply to hearings conducted by the Department of Workforce Services relating to medical assistance eligibility determinations.

(3) If a proceeding of the department, under Title 63G, Chapter 4, Administrative Procedures Act, relates in any way to Medicaid or Medicaid funds, the following may attend and present evidence or testimony at the proceeding:

(a) the director of the Office of Internal Audit and Program Integrity, or the director's designee; and

(b) the inspector general of Medicaid services, if an Office of Inspector General of Medicaid Services is created by statute, or the inspector general's designee.

(4) In relation to a proceeding of the department under Title 63G, Chapter 4, Administrative Procedures Act, a person may not, outside of the actual proceeding, attempt to influence the decision of the presiding officer.

Enacted by Chapter 362, 2011 General Session

26-18-604. Division duties -- Reporting.

(1) The division shall:

(a) develop and implement procedures relating to Medicaid funds and medical or hospital assistance funds to ensure that providers do not receive:

(i) duplicate payments for the same goods or services;

(ii) payment for goods or services by resubmitting a claim for which:

(A) payment has been disallowed on the grounds that payment would be a violation of federal or state law, administrative rule, or the state plan; and

(B) the decision to disallow the payment has become final;

(iii) payment for goods or services provided after a recipient's death, including payment for pharmaceuticals or long-term care; or

(iv) payment for transporting an unborn infant;

(b) consult with the Centers for Medicaid and Medicare Services, other states, and the Office of Inspector General for Medicaid Services, if one is created by statute, to determine and implement best practices for discovering and eliminating fraud, waste, and abuse of Medicaid funds and medical or hospital assistance funds;

(c) actively seek repayment from providers for improperly used or paid:

(i) Medicaid funds; and

(ii) medical or hospital assistance funds;

(d) coordinate, track, and keep records of all division efforts to obtain repayment of the funds described in Subsection (1)(c), and the results of those efforts;

(e) keep Medicaid pharmaceutical costs as low as possible by actively seeking to obtain pharmaceuticals at the lowest price possible, including, on a quarterly basis for the pharmaceuticals that represent the highest 45% of state Medicaid expenditures for pharmaceuticals and on an annual basis for the remaining pharmaceuticals:

(i) tracking changes in the price of pharmaceuticals;

(ii) checking the availability and price of generic drugs;

(iii) reviewing and updating the state's maximum allowable cost list; and

(iv) comparing pharmaceutical costs of the state Medicaid program to available pharmacy price lists; and

(f) provide training, on an annual basis, to the employees of the division who make decisions on billing codes, or who are in the best position to observe and identify upcoding, in order to avoid and detect upcoding.

(2) Each year, the division shall report the following to the Social Services Appropriations Subcommittee:

(a) incidents of improperly used or paid Medicaid funds and medical or hospital assistance funds;

(b) division efforts to obtain repayment from providers of the funds described in Subsection (2)(a);

(c) all repayments made of funds described in Subsection (2)(a), including the total amount recovered; and

(d) the division's compliance with the recommendations made in the December 2010 Performance Audit of Utah Medicaid Provider Cost Control published by the Office of Legislative Auditor General.

Amended by Chapter 167, 2013 General Session

26-18-605. Utah Office of Internal Audit and Program Integrity.

The Utah Office of Internal Audit and Program Integrity:

(1) may not be placed within the division;

(2) shall be placed directly under, and report directly to, the executive director of the Department of Health; and

(3) shall have full access to all records of the division.

Enacted by Chapter 362, 2011 General Session